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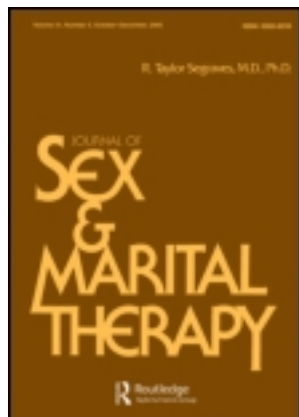
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### Partner Attachment as a Predictor of Long-Term Response to Treatment with Couples Therapy

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## **Partner Attachment as a Predictor of Long-Term Response to Treatment with Couples Therapy**

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*Vulnerability factors such as insecure attachment may have a lasting effect on the outcome of couples therapy, even long after discharge from treatment. Given that attachment has never been examined as an outcome predictor for couples therapy in the long term, the authors studied its effect on outcome during and after couples therapy. This prospective study included 71 inpatients participating in group couples therapy who the authors measured at baseline, immediately posttreatment at 2 months, and at 8 and 20 months, regarding two outcomes: problem-solving capacity (using the Interactional Problem Solving Questionnaire) and psychopathology (using the 90-item Symptom Check List). At baseline, the authors measured partner attachment (using the Experiences in Close Relationships Questionnaire). Mixed model analyses showed that attachment-related dysfunctional working models of self and others predicted less improvement in psychopathology ( $p = .04$ )*

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*and problem-solving capacity ( $p = .01$ ), respectively. Special attention to insecure attachment in couples therapy may therefore prove valuable in terms of outcome in the long run.*

## INTRODUCTION

Couples therapy typically aims at enhancing partner interaction and communication, and, in case of severe psychological distress, at reduction of psychopathology. Meta-analyses have found that various forms of couples therapy are effective (D. H. Baucom et al., 1998; Dunn & Schwebel, 1995; Shadish & Baldwin, 2005; Shadish et al., 1993). However, not all couples benefit from therapy. To further enhance treatment effectiveness, response to treatment analyses have been conducted to identify subgroups of patients who do or do not profit from couples therapy.

Several reviews of response to treatment studies (cf. Atkins et al., 2005; Gollan & Jacobson, 2002; Snyder, Castellani, & Whisman, 2006) have identified a great variety of predictors for marital satisfaction, the main outcome in most studies. These were (a) demographics (e.g., age, education, employment), (b) relationship factors (e.g., communication, commitment, marital distress, influence tactics), (c) individual characteristics (e.g., depression), and (d) the therapy process itself. Findings were inconsistent across studies. Moreover, studies suffered from two major limitations.

First, almost all studies were dedicated to the response immediately post-treatment. However, for a better understanding of the effects and limitations of couples therapy, it is necessary to predict the maintenance of treatment gain in the long term. This is of specific importance because approximately one third of the couples who respond to treatment report the recurrence of distress shortly after treatment has ended (Gollan & Jacobson, 2002). To date, only two studies have focused on the long-term response to couples therapy. One has found negative marital affect, poor problem-solving skills, depression, and low psychological resilience as the main predictors (Snyder, Mangrum, & Wills, 1993), and the other was only recently published and identified power processes (i.e., influence tactics) and expressed emotional arousal as the strongest predictors of marital distress years after termination of couples therapy (B. R. Baucom et al., 2009).

A second limitation of existing studies on the response to treatment is that stable personality-related factors are almost never examined as a predictor of outcome (Atkins et al., 2005). Especially in combination with prediction of the long-term treatment outcome, examination of such stable factors is important. It is therefore striking that attachment as an outcome predictor for couples therapy is absent in these analyses. Conceptually, one may view partner attachment as a relevant outcome indicator because it refers to bonding patterns in close relationships. Moreover, because attachment has been found to be moderately stable over time (Fraley, 2000), one may

expect that insecure partner attachment (like personality traits) may have an enduring effect on the outcome even long after treatment has ended.

This study aimed to make two contributions to the research literature on couples therapy. First, we examined the role of partner attachment as an outcome predictor. Second, we studied the potential effect of attachment during treatment but also long after treatment. For this goal, we followed patients for a substantial period (i.e., immediately posttreatment and at 8 and 20 months).

Partner attachment in this study was conceptualized in terms of its two empirically established underlying fundamental dimensions (Brennan, Clark, & Shaver, 1998), or working models (Bartholomew & Horowitz, 1991). The first is the (negative) working model of others, also labeled as *avoidance of intimacy*. This refers to an expectation of inaccessibility and unresponsiveness of partners to one's attachment needs, including support and consolation. The second is the (negative) working model of self, also referred to as *anxiety about rejection and abandonment*. This is described as an expectation of being perceived by partners as unacceptable or unlovable.

Both working models have been found to relate in a meaningful way to two outcomes that are of particular interest for couples therapy, namely problem-solving capacity and psychopathology. First, previous research, conducted outside the context of couples therapy, has found an association between dysfunctional working models of others (avoidance of intimacy) and inadequate problem-solving skills (Dozier, Lomax, Tyrell, & Lee, 2001; Kobak, Cole, Ferenz-Gillies, Fleming, & Gamble, 1993; Lopez et al., 1997). It seems likely that such an association would be found in couples as well, because successful problem solving in intimate relationships depends on trust between partners and the willingness to share rather than the avoidance of intimacy (Bartholomew & Horowitz, 1991). Second, dysfunctional models of self (anxiety about rejection and abandonment) have been found to be associated with increased levels of psychopathology (Conradi & De Jonge, 2009; Shaver, Schachner, & Mikulincer, 2005). This seems to suggest that diminished self-esteem in the context of relationships (i.e., feelings of unacceptability and unlovability) may make one vulnerable to depression and anxiety-related complaints. Together, these findings constitute the two hypotheses that guided the analyses in this study. In particular, we anticipated a long-term negative effect of a dysfunctional model of others on problem-solving capacity and a dysfunctional model of self on psychopathology.

## METHOD

### Patients and Setting

Subjects were inpatients from De Keerkring, a subdivision of the mental healthcare organization in The Netherlands, which is an expertise center

specialized in the treatment of couples experiencing severe relational problems and psychopathology. Married heterosexual couples were referred by other mental health services nationwide. These couples had previously received unsuccessful marital therapy, yet they were nevertheless motivated to continue their marriage or were unable to end it. Exclusion criteria for admission to therapy were low IQ, insufficient mastery of the Dutch language, suicidal risk, psychosis, and substance abuse.

The research protocol of the study was approved by the Research Committee and the Institutional Review Board of the Regional Mental Health Care Service Drenthe. All patients admitted to the group couples therapy between August 2005 and August 2007 gave informed consent for participation in the study. This resulted in a sample of 72 inpatients. Mean age of men and women was 53.9 years ( $SD = 9.9$  years; range = 27–72 years) and 51.0 years ( $SD = 9.7$  years; range = 25–70 years), respectively. Mean duration of relationship was 23.5 years ( $SD = 10.8$  years).

### Treatment Program

The group therapy for couples was an intensive inpatient treatment program consisting of 7 weeks of daily (psycho-)therapy, which was provided to 5 couples at a time. In addition to the group sessions, there was an opportunity for individual or couple sessions. The couples stayed from Monday to Friday at the treatment residence and went home for the weekends to practice what was learned during the therapy program. On Monday, the group started with the evaluation of the weekend and set new targets for the upcoming week. The afternoon was dedicated to psychomotor therapy and communication training. Tuesdays started with arts therapy and the afternoon was organized around a specific weekly theme, including positive and negative influences of the family of origin, partners' views of the past, present and future of the relationship, boundaries between self and other, conflict handling, intimacy and sexuality, and tasks and responsibilities. Wednesday was dedicated to psychomotor therapy and group therapy, and in the afternoons couples were free. Thursdays started with activity therapy, followed by sociotherapy and communication training. Last, on Fridays the couples were split up and attended men's and women's groups.

The core team included four psychotherapists, two family therapists, two sociotherapists, and a consultation psychiatrist. In addition, a number of nonverbal therapy specialists (i.e., a psychomotor therapist, an art therapist and an activity therapist) provided sessions. The group couples therapy was eclectic by nature, incorporating elements from behavioral therapy (including communication training), system therapy, dynamic approaches, and nonverbal disciplines including psychomotor therapy, art and activity therapy. The treatment had proven to be effective for the group as a whole (Bout, Sytema, & Rankin, 2008; Sytema & Bout, 2006).

## Measurements

The instruments used in this study were completed separately by both spouses. At baseline, we administered the Dutch version (Conradi, Gerlsma, Van Duijn, & De Jonge, 2006) of the Experiences in Close Relationships Questionnaire (Brennan et al., 1998), measuring adult attachment within romantic relationships in past and present. It contains two scales corresponding with the constructs mentioned in the two hypotheses. The first measures model of others—avoidance of intimacy—(Cronbach's  $\alpha = .88$ ) and the second measures model of self—anxiety about rejection and abandonment—(Cronbach's  $\alpha = .86$ ). A 7-point Likert-type scale ranging from 1 (*disagree strongly*) to 7 (*agree strongly*) was used to score the items. The Dutch Experiences in Close Relationships Questionnaire was found to be a valid and reliable measure (Conradi et al., 2006).

Two outcome measures were administered at four points in time: pretreatment at baseline, immediately posttreatment (i.e., 2 months after baseline), and at 8 and 20 months during follow-up. First, we used the Interactional Problem Solving Questionnaire to measure the level of problem-solving capacity in couples. The questionnaire includes 21 items each with five response categories, and it has demonstrated good internal consistency (Cronbach's  $\alpha = .90$ ) and convergent validity (Lange, 1983). Second, the Symptom Check List (Arrindell & Ettema, 1986) was administered. It includes 90 items each with five response categories. For our analyses, we used the total score, an overall measure of psychopathology (Cronbach's  $\alpha = .98$ ).

## Statistical Analyses

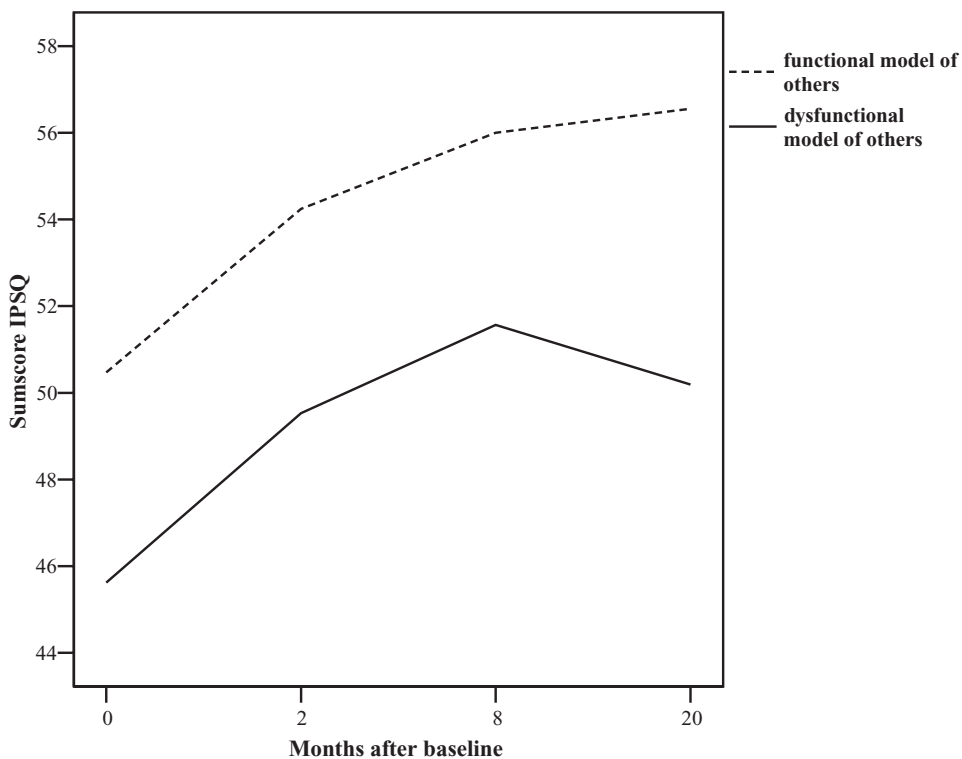
First, we used both scales of the Experiences in Close Relationships Questionnaire for the creation of the four styles of attachment-related cognitions and behaviors (Bartholomew & Horowitz, 1991): secure, fearful, preoccupied and dismissing. For this, we first replicated the statistical procedure (a two-step cluster analysis) prescribed by Brennan et al. (1998) in a fairly representative Dutch general population sample (Conradi et al., 2006). We subsequently computed Fischer's linear discriminant functions for this general population sample, and applied the obtained norms to the patients of this study to classify them into one of the four styles of attachment. We were then able to distinguish individual patients according to the level of functionality of their model of self and model of others. This resulted in four groups: (1a) patients with a functional model of others (secure and preoccupied patients) or (1b) dysfunctional model of others (dismissing and fearful), and (2a) patients with a functional model of self (secure and dismissing) or (2b) dysfunctional model of self (preoccupied and fearful).

We then plotted the outcomes (i.e., the Interactional Problem Solving Questionnaire and Symptom Check List scores, pretreatment, immediately posttreatment, and at 8 and 20 months during follow-up) for patients stratified according to their level of (dys-)functionality of their working model

of others and self, respectively. On the basis of these plots, we developed general linear models (Bryk & Raudenbush, 1987) using the mixed models approach for repeated measures in SPSS. This allowed us to analyze possible differences between these groups of patients concerning the courses of problem-solving capacity and psychopathology. We conducted two mixed model analyses for (a) the course during treatment with pretreatment level of problem-solving capacity or psychopathology as covariate, and (b) the course after treatment with immediate posttreatment level of problem-solving capacity or psychopathology as covariate. We included these covariates in the analyses to adjust for initial differences between groups. Significance level for all analyses was set at  $p < .05$  (two-tailed).

## RESULTS

Figure 1 visually represents the response to treatment in terms of the scores on problem-solving capacity during treatment and the follow-up period. The



**FIGURE 1.** Course of problem-solving capacity in patients with or without dysfunctional model of others.



**TABLE 1.** Mixed Model Analyses of Repeated SCL-90 and IPSQ Measurements

	Functional model of others (avoidance of intimacy; $n = 37$ )	Dysfunctional model of others (avoidance of intimacy; $n = 34$ )	
IPSQ during treatment <sup>a</sup>	53.3 (1.2)	50.6 (1.3)	$F = 2.22, p = .14$
IPSQ posttreatment <sup>b</sup>	55.2 (0.8)	52.0 (0.8)	$F = 6.34, \mathbf{p} = .01$
	Functional model of self (anxiety of rejection; $n = 29$ )	Dysfunctional model of self (anxiety of rejection; $n = 42$ )	
SCL-90 during treatment <sup>a</sup>	139.1 (5.9)	146.2 (4.8)	$F = 0.77, p = .38$
SCL-90 posttreatment <sup>b</sup>	130.5 (4.5)	143.2 (3.7)	$F = 4.38, \mathbf{p} = .04$

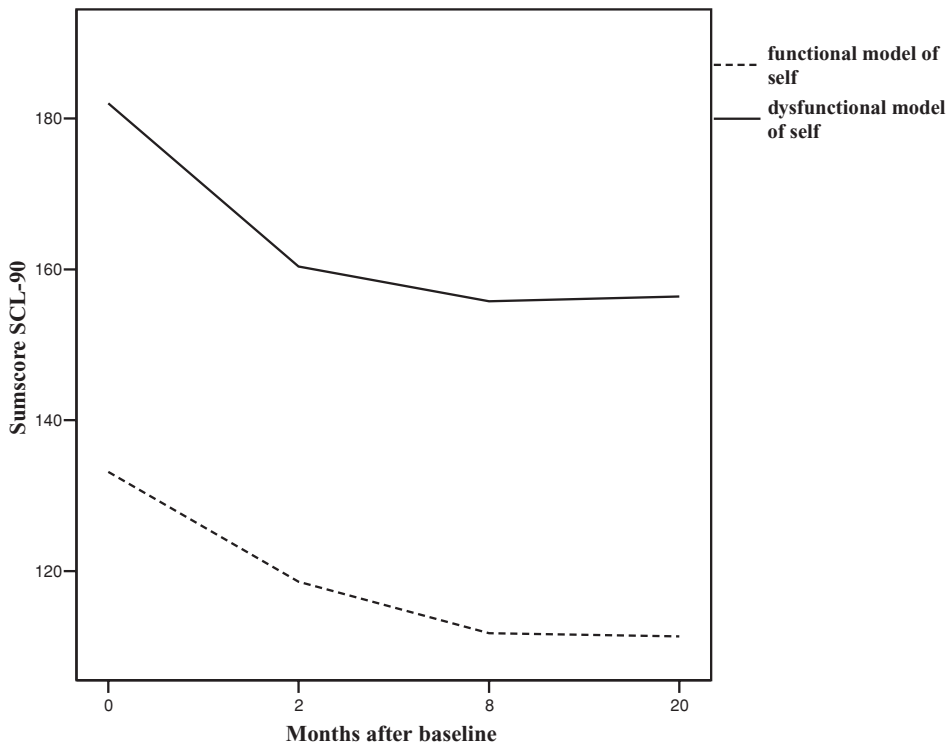
*Note.* IPSQ = Interactional Problem Solving Questionnaire; SCL-90 = 90-item Symptom Check List. Bolded values are statistically significant ( $P < .05$ ).

<sup>a</sup>Dependent variable at 2 months with baseline score as covariate.

<sup>b</sup>Dependent variable at 8 and 20 months with score at 2 months as covariate.

figure shows that patients with a functional model of others reported an on-going increase in problem-solving capacity during treatment and follow-up. It shows that for patients with a dysfunctional model of others the initial slope of increase in problem-solving capacity was similar, although at a consistently lower level, yet this trend reversed posttreatment into a decrease in the reported problem-solving capacity. With the first mixed model analysis, we tested for possible differences during treatment, with the pre-treatment score on problem-solving capacity as covariate (to adjust for initial differences) and the immediate posttreatment score on problem-solving capacity as dependent variable. No statistically significant difference between individuals with a functional or a dysfunctional model of others emerged immediately posttreatment (see Table 1). With the second mixed model, we tested for possible differences after treatment during follow-up with the score on problem-solving capacity immediately posttreatment as covariate and the scores on problem-solving capacity at 8 and 20 months after baseline as dependent variables. The difference was statistically significant,  $F = 6.34, p = .01$ , (see Table 1).

Regarding total psychopathology (Symptom Check List), results were similar although less pronounced. Patients with a functional model of self improved during the entire follow-up, whereas individuals with a dysfunctional model of self initially improved as well, although at a lower level (see Figure 2). The mixed model analysis during treatment, analogous to the one described above for the course of the problem-solving capacity score, revealed no statistically significant difference. In contrast, the mixed model analysis after treatment showed a statistically significant difference regarding psychopathology,  $F = 4.38, p = .04$  (see Table 1).



**FIGURE 2.** Course of psychopathology in patients with or without dysfunctional model of self.

## DISCUSSION

In this study, we found that insecure partner attachment, in terms of dysfunctional models of others and self, had a negative effect on treatment gain in the 18 months after discharge from couples therapy.

### Strengths and Limitations

To our knowledge, this study is the first to examine the role of partner attachment in the long-term response to couples therapy. An additional strength of this study is the measurement of attachment by the Experiences in Close Relationships Questionnaire, which is the self-report questionnaire of choice in adult attachment research. Third, outcomes were measured prospectively at multiple points in time rather than on the basis of a single assessment. Last, the duration of follow-up was a substantial 20 months, or 1.5 year after discharge. Because of the supposedly enduring effect of attachment on treatment outcome, this extended follow-up was very important. A limitation of this study was the restricted sample size, but clear statistically significant results were nevertheless obtained. However, replication of the results is needed.

## Working Model of Others and Problem-Solving Capacity

The initial gain in problem-solving capacity reported by couples in our study was hard to maintain in the long term for the most vulnerable group. The subgroup with a dysfunctional working model of others partially relapsed into less favorable problem-solving skills. We assume this reflects the impact of ingrained expectations of partners' inaccessibility and unresponsiveness on one's attachment needs, such as support and consolation. Old patterns of attachment-related interpersonal distrust appear to have reemerged, to some extent, in these patients. This fits with the definition of attachment avoidance as involving fear of dependency and interpersonal intimacy, an excessive need for self-reliance, and reluctance to self-disclose. To illustrate this further, during an experimental interpersonal problem-solving task, patients relying on avoidant attachment strategies tended to reject their partners, who, in turn, reported sadness (Dozier et al., 2001). This avoidant approach to problem solving is reminiscent of the power processes that Baucom et al. (2009) found to be predictive for treatment outcome in the long term. Power processes, or hard-influence tactics, are characterized by low degrees of collaboration and connectedness, and an unwillingness to share power.

The long-term effect of poor problem-solving skills after couples therapy was demonstrated by Snyder et al. (1993), who found it to be a significant predictor for long-term marital distress and dissatisfaction. It is interesting that in an earlier study (Conradi et al., 2006), we found a substantial association between working model of others and relationship dissatisfaction ( $r = 0.62$ ,  $p < .01$ ). This means that a dysfunctional model of others not only has a negative prospective effect on problem-solving capacity, but also has a direct association with relational dissatisfaction as well.

## Working Model of Self and Psychopathology

Although the subgroup of patients with a dysfunctional model of self improved substantially during treatment and partly during follow-up, the overall level of psychological complaints remained much higher compared to patients with a functional model of self. The adjusted difference was approximately 13 points on the Symptom Check List and unadjusted more than 40 points (see Figure 2). This suggests that a negative model of self constitutes a significant vulnerability for Axis I psychological complaints. This is not hard to understand when one keeps in mind that a negative model of self refers to the expectation of being perceived by partners as unacceptable or unlovable, which manifests itself in a fear of interpersonal rejection or abandonment and an excessive need for approval from others.

In the Introduction, we stated that it is important to study stable factors such as personality and attachment in order to evaluate the effectiveness of couples therapy in the long term. To date, neuroticism is the only personality

factor that has been studied as a predictor of response to couples therapy (Atkins et al., 2005; B. R. Baucom et al., 2009). These studies found that neuroticism was not significantly related to response to treatment. It is interesting that in a review on associations between attachment and personality, a substantial correlation was reported between dysfunctional model of self and neuroticism (Nofle & Shaver, 2006). In earlier research (Conradi et al., 2006), we found a correlation of 0.61 ( $p < .01$ ). In contrast with neuroticism as examined by Atkins et al. (2005) and B. R. Baucom et al. (2009), we found model of self to be a significant predictor for treatment outcome. However, the sample on which Atkins et al.'s (2005) and B. R. Baucom et al.'s (2009) studies were based, was relatively functional, with only 16% having a current psychiatric diagnosis, whereas in our sample 76.5% had an ICD-10 diagnosis. Moreover, Atkins et al. (2005) and B. R. Baucom et al. (2009) applied marital satisfaction as an outcome measure, whereas in our study psychopathology (next to problem-solving capacity) served as a criterion measure. It is more likely to find a higher correlation of neuroticism (or working model of self) with psychopathology than with marital satisfaction.

### Clinical Implications: Long-Term Effect of Attachment Patterns

Results indicate that partner attachment is a significant predictor for response to couples therapy in the long term. It is interesting that this became apparent only posttreatment during follow-up. Whereas patients with functional models of self and others continued to improve after discharge, patients with dysfunctional models improved less or even worsened during follow-up. This suggests that attachment-related vulnerability seems to restrict further effect of couples therapy long after discharge. Earlier, we found a test-retest stability of 0.76 and 0.79 for the Experiences in Close Relationships Questionnaire scales measuring working models of self and others respectively over a 12-month period in a clinical sample. This relatively high test-retest stability underlines the potential for partner attachment to have a lasting influence.

Although neuroticism may be a powerful predictor for psychopathology (Clark, Watons, & Mineka, 1994) and to a lesser extent for marital satisfaction (Karney & Bradbury, 1997), we prefer attachment as a predictor in studies analyzing response to couples therapy for two reasons. First, attachment is easier to modify than neuroticism because it is more environmentally and less genetically based (Nofle & Shaver, 2006). Second, neuroticism is not specific enough to offer information on the direction, content and approach of couples therapy. Knowledge about attachment quality, in contrast, may guide therapeutic interventions because it directly refers to stable mechanisms underlying interpersonal problems and processes of affiliation in relationships.

The results concerning the subgroups with dysfunctional working models suggest that insight into the quality of the attachment-related working models in the diagnostic phase may help to enhance couples therapy. A

diagnosis-driven treatment plan may guide the choice of appropriate treatment goals, so that treatment resources will be efficiently aimed at specific underlying vulnerabilities (i.e., at one or both working models of attachment). Moreover, it may justify more intensive treatment in order to improve and maintain the outcome in the long term. This does not preclude couples therapy from any tradition. Cognitive behavioral therapy, emotion-focused therapy for couples (Johnson & Best, 2003), more psychodynamic approaches or eclectic combinations directed at insecure attachment may be indicated for these vulnerable patients.

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